FINANCIAL ELIGIBILITY AND ASSETS CERTIFICATION

(Please refer to the reverse side for instructions to complete this form.)

Ryan White Care Act Health Insurance Premium Payment Program

1. Initial CARE/HIPP enrollment date

HEALTH INSURANCE INFORMATION

2. Client's name   (Last)   (First)   (MI)   Social security number

3. Type of medical insurance

☐ Cal-COBRA   ☐ HIPIC   ☐ Conversion (Rx)
☐ COBRA   ☐ OBRA   ☐ Private self-pay

4. Type of coverage

☐ Individual   ☐ Family

FINANCIAL ELIGIBILITY DOCUMENTATION

Please include information to substantiate CARE/HIPP enrollment (i.e., SSA or SDI award/denial letters, Medi-Cal Notice of Action letter, etc.).

7. Sources of Family Income	Amount	Begin Date	End Date
Supplemental Security Income	$ _____	_____	_____
Social Security Disability Income	_____	_____	_____
State Disability Income	_____	_____	_____
Temporary Assistance for Needy Families	_____	_____	_____
Unemployment benefits	_____	_____	_____
Long-Term Disability Insurance	_____	_____	_____
Wages (part-time)	_____	_____	_____
Other: _____	_____	_____	_____

8. **Total monthly income** $ _____

9. **Total assets**
   (Cannot exceed $6,000) $ _____   (Please complete the Assets Certification Checklist)

10. Medi-Cal application date   _____/_____/_____

11. Will income change in the next 12 months?   ☐ Yes   ☐ No

DECLARATION: I have thoroughly read and understand the provisions of the CARE/HIPP enrollment policy. I further agree to provide documentation to my benefits counselor to substantiate my eligibility. I understand my insurance premiums will be paid as long as I am eligible, until I enroll in the state or a county HIPP program; *or* until I am Medicare-eligible. I agree to immediately notify my benefits counselor of any changes in my circumstances which affect program eligibility or health insurance coverage.

Client's signature   Date

➤

Policyholder's signature   Date

➤

Benefits counselor's or case manager's signature   Date

➤

INSTRUCTIONS FOR COMPLETING
FINANCIAL ELIGIBILITY AND ASSETS CERTIFICATION

The following instructions correspond to the numbered section on the face of the form. All sections should be completed, except where indicated. Please print clearly and in black ink.

1. **Initial CARE/HIPP enrollment date:** The date of the first CARE/HIPP premium payment.

2. **Client's name:** Please enter the client's last name, first name, and middle initial.

3. **Type of medical insurance:** Please check the appropriate box that identifies the type of policy paid by CARE/HIPP. (HIPC is also known as PAC Advantage.)

4. **Type of coverage:** Please check the appropriate box that describes the applicant's type of insurance coverage.

5. **Sources of income:** Please identify the sources of income received by the family and include the monthly amount and the dates payments began and end (if applicable). Please include copies of the documents that verify the information.

6. **Total monthly income:** Please enter the total monthly income of all combined sources.

7. **Total assets:** Please enter the total dollar value of the family's assets. Please include verification documentation if assets exceed $2,000.

8. **Medi-Cal application date:** All clients whose assets are $2,000 or less at the time of application or recertification *must* apply for benefits under the Medi-Cal program or a county organized health system.

9. **Income:** Please check the appropriate box to indicate the status of applicant's income.

IMPORTANT: **Carefully review the information in the boxes prior to signing the completed application.**

DECLARATION: The declaration indicates that all eligibility requirements have been met.

SIGNATURES: The client, the policyholder, and the benefits counselor/case manager are required to sign and date the form. If the client is the policyholder, sign on the first line only. If the client and policyholder are different, both lines must be signed.